Table S. Questionnaire

1) Sex of child
   - ☐ Male
   - ☐ Female

2) Current age of child _____ years

3) Presence of siblings
   - ☐ No
   - ☐ Yes

4) Underlying disease
   - ☐ No
   - ☐ Yes (1. Asthma 2. Epilepsy 3. Other) _____

5) Has your child ever experienced any ADRs caused by medication, over-the-counter drugs, and supplements? If so, please fill in the product name your child used and ADRs.

Product name _____ ADR _____

Product name _____ ADR _____

Product name _____ ADR _____

Product name _____ ADR _____

Product name _____ ADR _____

Product name _____ ADR _____